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Lisa Riggs, MSN, RN, ACNS, CCRN-K, AACN President-Elect

It’s now my great honor to welcome our President-elect Lisa Riggs to the stage.

Lisa is system director of regulatory readiness at Saint Luke’s Health System in Kansas City, Missouri. She has worked most of her career at Saint Luke’s, serving as director of quality and patient safety, program director of CV quality, clinical director of patient care services and a clinical nurse and clinical nurse specialist.

Lisa has had a long relationship with AACN. She’s been active with the Greater Kansas City Chapter for nearly 30 years. She’s been an AACN ambassador, chaired AACN’s Evidence-Based Practice Resource Work Group twice, served on the AACN Nominating Committee and presented at NTI. She also served a previous term as a director on the AACN board — where she was secretary — and a concurrent one-year term on the AACN Certification Corporation Board.

Lisa earned a Master of Science in Nursing from the University of Missouri in Kansas City and a Bachelor of Science in Nursing from the University of Iowa. She’s also a member of the American College of Cardiology.

She’s had a great nursing career. But if she hadn’t been a nurse, she says she would have been a sportscaster. And this isn’t surprising considering her personal motto is “Just do it!”

Her favorite thing in the world is hanging out and laughing with family and friends, and she loves music. She says, “I can find a melody/genre to fit every mood.” Of course, she also says, “I wish I could sing.” What Lisa can do is bake, and she hopes to spend most days of her retirement baking desserts to share.

The quality she admires most in people is the ability to give feedback without judgment. And that if she were reincarnated she would come back as a golden retriever.

“Think about it,” she says “They’re loyal, content, happy with simple pleasures, have GREAT hair and get to nap all day.”

Lisa really wishes more people knew that she loves to relax and play as much as she loves to work. So I’m hoping we’ll get a chance to relax and play as soon as NTI is over. Right now, though, let’s give a big welcome to someone I love to hang out and laugh with, Lisa Riggs.
President-Elect’s Keynote

NTI 2018

In 1990, nearly two-thirds of the children in Vietnam under the age of 5 were starving.

A program where supplemental food was given to families had been interrupted, and the health of the country’s children rapidly declined. A team of volunteers from Save the Children went to Vietnam to see if they could help.

In one village, the volunteers quickly noticed that some of the children were actually healthy and well nourished. And, they wondered, how could that be? Were the caregivers of these children doing something different?

All villagers thought they were preparing meals the same way. Initially, there appeared to be nothing unique about the families with well-nourished children. It appeared the children received the same amount of food, and there was no difference in cooking techniques.

So why were some kids well-nourished and others not?

When the volunteers watched the villagers prepare meals, they noticed two small differences between households of well-nourished children and the others. In the households of well-nourished children, caregivers frequently washed their hands. Those same households also fed their kids different kinds of food. Specifically, the well-nourished children had tiny shrimp and crabs gathered from the rice paddies and greens from sweet potato plants added to their food. You see, in Vietnam at that time, most households followed two traditions. First, shrimp and crabs were reserved for working adults to maintain their strength and health. Second, the greens from sweet potato plants were stigmatized as a low-class food and not commonly added to meals.

Hand-washing and the addition of small amounts of protein and vitamins were the two practices the volunteers observed in well-nourished children. That’s it. Two small practices that deviated from the norms of the culture, but they yielded lifesaving results. Two simple positive practices that made a monumental difference. Social innovation scientists call this POSITIVE DEVIANCE. The approach focuses on those who demonstrate exceptional performance, despite facing the same constraints as others.

The volunteers from Save the Children wanted to spread this practice, but they knew it wouldn’t be easy. Volunteers from outside the country couldn’t just come in and tell the local villagers what to do and how to care for their kids. They knew the change had to come from within the village.

So the volunteers recruited the positive deviant caregivers to prepare meals with those whose children were malnourished in order to share the two positive practices. Side by side, the villagers changed their circumstances. Ultimately, what started in one village spread to 150 villages impacting 2.2 million people. Decades later, these practices have normalized — part of the routine — and the children remain well nourished. All because of good hand hygiene and the sharing of shellfish and greens.

I have mentioned positive deviance a couple of times now. It’s based on a principle that says, “It is easier to ACT your way into a new way of thinking than it is to THINK your way into a new way of acting.” OK, wait. That’s a very big thought. Let me say it again: “It is easier to ACT your way into a new way of thinking than it is to THINK your way into a new way of acting.”

Deviant practices are a mechanism that allows us to act our way into a new way of thinking. They jar us. They shake us up. They push us in new directions. And they do this simply by making us question our usual practices to allow us to arrive at a better result.

So let me ask you a question. How can we nurses act our way into a new way of thinking? And eventually a new way of being?

It just got me thinking: How would I act if I were truly in charge of my practice the way I want to be? What would it be like if we designed the EMR around the way we work? What if we were engaged to find solutions to our staffing challenges? What if we pushed back on regulations that don’t make sense?

It would be something like nirvana, don’t you think? It would actually be you and me as nurses making our optimal contribution.

Well, this might be a vision of nirvana, but I sometimes catch a glimpse of it. I want to tell you what I mean.

But before I go any further, I have a confession to make. I spend most days at work reading and interpreting
regulations. That might lead you to believe that I like regulations. Well, I don’t. Like most of you, I feel stifled and shackled by the volume of regulations imposed on our work. So why do I go to work every day and focus on regulations? Why? Because I love to find ways for us to flourish in our practice DESPITE all the regulatory requirements. You see, in my job, I assist healthcare practitioners to focus on how they wish to care for patients while complying with multiple regulatory requirements.

Don’t worry — I haven’t crossed over to the dark side. Let me share an example of how I act to challenge conventional thinking.

I’m sure many of you have gotten a daily physician’s order for non-violent or med-surg restraints; you know — the soft wrist restraints used for confused patients to keep them from extubating themselves or pulling out their lines. We had the same practice within the hospitals of my health system. I was told by everyone I asked — bedside nurses, quality analysts, nursing directors — that we did this because CMS says it HAS TO BE DONE.

Now, I’m the type of person who likes to challenge. I like to challenge the status quo. I don’t like being told that I must do something without being given the rationale. I used my voice to find out if it was really true that we had to have a daily order to use the restraints. I was methodical and purposeful. I must have read the CMS regulations 10 times. Then I reviewed The Joint Commission standards.

And you know what? I couldn’t find that requirement written anywhere. So, still being purposeful and thinking critically about my approach, I again used my voice and sent an email to CMS and The Joint Commission. I asked if this really was a requirement.

And guess what? It’s NOT!

Here’s what CMS said, and I quote: “There is no requirement for a daily renewal order for non-violent/ non-self-destructive restraints. This is up to the organization to define per policy.”

I felt like a kid in a candy store. It was like I had won the Powerball.

I immediately shared the good news with the shared governance councils. We worked to change our restraint policy and eliminated the statement requiring a daily renewal order for non-violent restraints. We’ve also changed our CPOE order and our EMR documentation. We’ve removed the daily alert to have the order renewed. No more reminders popping up on the computer telling physicians and nurses to get a renewal order. Most important, we’ve changed our PRACTICE!

This is just a small win. But what if we could have dozens of these small victories at hospitals and healthcare systems across the country? What if we could apply them to the whole of nursing practice?

In 2016, the Institute for Healthcare Improvement — the IHI — facilitated a weeklong initiative called Breaking the Rules for Better Care. Senior leaders at 40 organizations across the United States asked patients, families and staff, “If you could break or change one rule in service of a better care experience for patients or staff, what would it be and why?”

Nurses, our healthcare colleagues and patients across the country identified nearly 500 rules to break to improve patient care. Five hundred! These 500 rules could be placed in three general categories. The first category was rules that need clarity. These are rules that aren’t really rules but myths or habits. Second, there are rules that need to be redesigned. Or administrative rules that leaders have the power to change. And, finally, rules that need advocacy, because they are in place due to regulations and policies beyond organizational control.

Here are a few examples that I think will resonate with you. An organization wanted to change the visitation policy restricting children in the ICU. This recommendation came about because of a young mother in the ICU who was critically ill after delivering her baby. Her prognosis was guarded, and her spirits were low. The staff feared that she may not live to meet her newborn child. Her husband asked to have the infant brought in to see the patient, but hospital policy did not allow visitors younger than 12 into the ICU. Now, you know what happened! The nursing staff broke the visitation rule and brought the baby to its mother. The reunion was a happy one, and the mother’s spirits and motivation to live improved. It was a long, hard road to recovery like we sometimes see in the ICU, but the young mother did survive and was eventually discharged to her husband and her infant child.

This story ended happily, but the nurses wondered what would happen to other critically ill patients who
wanted to see their children or grandchildren? This was a rule that needed to be redesigned, and the organization, led by strong nursing, used their power to change it.

Another hospital wanted to get rid of a policy that their inpatient pharmacy could not send inhalers home with patients being discharged. How many of you have run into this situation? The patient is prescribed a new inhaler while hospitalized, yet you are not allowed to send it home with the patient. You have to toss it at discharge. The patient is inconvenienced at discharge and has to purchase another inhaler at a retail pharmacy ... if they have the means to get to the pharmacy. This hospital contacted their state's board of pharmacy and learned this was a myth, a misinterpretation of the regulation. The inpatient pharmacist could relabel the patient's inhaler with the required elements, provide instructions on the inhaler and send it home with the patient. This redesigned practice eliminated an inconvenience to the patient, reduced waste and potentially saved the hospital — and the patient — a readmission.

Finally, several hospitals identified a CMS rule they would like to break. The rule that patients must have a three-day inpatient stay to have post-acute skilled nursing care expenses covered. The IHI convened a group of hospital leaders and CMS officers to discuss the challenges this rule creates for hospitals, patients and the healthcare system. With a collective voice and a collaborative spirit, the possibility now exists that this rule will be changed in the future.

At times it feels like these outside forces are driving our practice. The Break the Rules initiative found that in reality only a quarter of the rules getting in the way of patient care were imposed by outside regulatory agencies. That means 75 percent were the result of a misinterpretation of the rules or were self-imposed — like requiring a daily order for non-violent restraints. That means 75 percent of the rules are within our control.

These examples show the strength we have when we use our voices to change and improve the lives of our patients. And impact our work environment!

When we use our collective voice and the strength we have as nurses, we can invent our future — not become victims of it. Our voice and our strength give us power. The power we need to change this profession we love.

These empowering actions inspired our theme this year: Our Voice, Our Strength.

I believe these words and the power behind them show us how to ACT our way into a new way of thinking.

The families in Vietnam eradicated malnutrition because Save the Children noticed small changes one village made. It was the community using their voice and their strength who drove the change. It was a team of ICU nurses that changed a visitation policy in the name of better patient care.

Doesn’t the most lasting change almost always come from within the community … or our hospital or unit? It is not driven by outside experts. But if those of us inside that hospital or unit don’t do it, change will still occur. And sometimes at great risk. What is imposed on us by others often produces outcomes that aren’t optimal.

Reinventing our future CANNOT be left to outside experts or a tedious study from a think tank. It must be from the efforts of nurses everywhere who are dedicated to the care we deliver and the lives of our patients. It must come from us. It must come from our community of exceptional nurses. It will result from the power of Our Voice, Our Strength.

“Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure.”

I love these inspiring words from Marianne Williamson. They remind me that fear and power both dwell within us. Let’s be courageous and reinvent our future. We can create the workplaces we want and need when we use our voice. Let’s confidently step into our strength.

Will you join me? Let me hear your voice! Will you join me?

Our Voice, Our Strength, makes us powerful beyond measure.

Thank you!